EXHIBIT A

(Discharge Notes from Tripler Army Medical Center 12/18/06 to 12/27/06)

541 3545 Debra - F41

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Personal Data - Privacy Act 1974 (PL 93-579)
Discharge Notes

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27 Dec 2006@0839 INPT Register # 511507 PSYCHIATRIST
Discharge Summary - Adm: 18 Dec 2006@2115 Disc: 27 Dec 2006@0839
Personal Data - Privacy Act of 1974 (PL 93-579)
Automated Version of 691-R-E (Modified)

DISCHARGE SUMMARY FOR TOWER,JOSEPH C
Date: 27 Dec 2006 Register #511507

ADMISSION DATE: 18 Dec 2006@2115 DISCHARGE DATE: 27 Dec 2006@0839

1. PRINCIPAL DIAGNOSIS:
Axis I: psychosis nos
depression nos
nicotine dependence

2. OTHER DIAGNOSIS:
Axis II: deferred
Axis III: chronic Hepatitis C, seizure disorder
Axis IV: traumatic brain injury in past, legal problems
Axis V: 30

3. PRINCIPAL PROCEDURE/OPERATION:
ward milieu, to include individual, group and occupational therapy
pharmacotherapy

4. OTHER PROCEDURES/OPERATIONS:

5. PHYSICIAN DISCHARGE NOTE:
Chief Complaint/Reason for Consult: VAB with 90% SC, paranoid patient being admitted from Waihawa to 3B2

HPI: Patient has not been feeling right for ten days: feeling confused and scared. People "said things" and are after him, and since he has problems seeing things, he cannot tell what's real and what is not. He sees people in camouflage and weapons hiding in trees. He follows up at the VA clinic and was told that he could go to 3B2 for help, but did not feel safe enough to go to the ER at Tripler and went into Waihawa ER because he lives across the street. Patient has not been taking his medications because he does not feel he needs them when he has to "fight to survive." Patient denied SI, not sure about SA in the past. Denies HI, current AVH. Denies AH in the past.

Name: TOWER,JOSEPH C
Spon: TOWER,JOSEPH C
Rank: AIRMAN
Unit:
MTF : TRIPLER AMC, HI
Ins : N Ins Co:
MC Status: NOT ENROLLED
PCM:

FMP/SSN: 20/259154615 Reg#: 511507
Ward/Bed: VAPSY 3B501-A MEPRS: AFAB
PCat: K61 DOB: 21 Aug 1961 Sex: M
Outpt Rec Rm: TRIPLER OUTPATIENT RECORD
H#: 748-4301 x306 HIPAA: ? PHIR:
VA: NONE
Reg comm: VET, CALL X5853 FOR PRE AUTHOR
POC:

PROGRESS NOTES/TAMC FORM 691-R-E (Modified)

EXHIBIT A

Occasionally has VH as mentioned.

PPsychHx: unsure except for MVA with TBI in 1979 and depression, anxiety, and paranoia. Patient does not like haldol.

Relevant Medical/Surgical/Trauma Hx: Patient has been on interferon for 5.5 months. Had TBI s/p MVA in 1979 for which he had L craniotomy. Hepatitis C, on IFN and ribavirin therapy, seizure d/o, last attack >1 year ago.

Relevant Family Hx: denies, father is 72, pt reportedly never met mother.

Relevant Social Hx: denies drugs or alcohol usage. Smokes 1-1.5 ppd since age 10. Never used IV drugs. Last drug was ice, 14 months ago.

MSE
General Description: Pleasant appearing bearded male ASA lying on the couch in a blanket.
- Alert and oriented x4
- Good eye contact
- Well groomed in cilivian clothes
- Fair personal hygiene
- Slightly anxious

Behavior / Attitude
- Able to establish a good rapport
- Speech: Appropriate rate
- Normal tone
- No involuntary movements
- No akithisia
- No psychomotor agitation

Mood / Affect
- mood: anxious, "confused"
- affect: unrestricted

Thought Process / Content:
- TP: linear, mostly logical
- TC: No SI/HI or AVH as above
- Cognition: grossly intact
- Insight: fair
- Judgment: fair

Relevant Labs/Imaging/Ancillary Studies: negative UDS, TSH 1.05, LFTs negative ALT 36 AST 17, low cell counts: 3.9WBC, 13/5/40.2 H&H, 133 platelets.

Relevant Physical Exam Findings:
Head: NC/AT
Cor: S1, S2 RRR -m/r/g
Pulm: CTA B/L, -w/c/r
Abd: soft, NT/ND NABS, no hepatosplenomegaly
Ext: -c/c/e
Neuro: CN II-XII intact, DTR depressed on R side of body, +1 on Left side. R sided weakness on shoulder 4/5, 5/5 strength otherwise despite subjective chronic weakness in rest of R sided body, paresthesias on R palmar hand and fingers and DIP areas on dorsal side, unable to elicit plantar reflexes. Patient was ataxic and felt dizzier than normal, unable to walk heel to toe. Romberg before even closing eyes.

HOSPITAL COURSE:
Pt was admitted voluntarily to 3B2. He was restarted on a med regimen of Abilify 10mg qd, Wellbutrin ER 150mg, Remeron prn insomnia, and Buspar 15mg qam. Pt was also continued on his ribavirin per his outpatient regimen. After several days of admission, pt reported decreased VH and had decreased anxiety, and paranoid fears. He was able to participate appropriately in group and occupational therapies. He did still report fears of involvement with past associates but did not need to act offensively. Pt was discharged home on Hospital Day 10.

6. SPECIFIC INSTRUCTIONS:
1) Return to ER or call 911 if you have thoughts of hurting yourself or others.

2) You should continue the following medications after discharge:
--Abilify 10mg: take one tablet daily at bedtime
--Wellbutrin SR 150mg: take one tablet every morning
--Remeron 30mg: take one tablet daily at bedtime
--Buspar 15mg: take one tablet every morning
--Gabapentin 300mg: take one tablet twice a day
Two weeks supply of above medications dispensed on discharge.
You should also continue the following as previously prescribed:
--ribavirin until the first week of January

(Patient reported having supply at home)

3) You should follow up with
Debra Soto, CNS, on Tues. Jan 2, 2007 at 11:00AM and
Mental Health Rehab on Monday, Wednesday, and Friday

FOR MORE HEALTH CARE INFORMATION:
For TRICARE Enrollees:
Your Primary Care Clinic:
Health Care Answering Service, 1-866-303-1159
World Wide Web Address: http://www.tamc.amedd.army.mil/

7. ACTIVITY LIMITATIONS:
No lifting over pounds for

8. RXs:

MIRTAZAPINE(REMERON)--PO 30MG TAB (Order Date: 26 Dec 2006)	TAKE ONE TABLET BY MOUTH EVERY NIGHT
BUPROPION (WELLBUTRIN SR)--PO 150MG (Order Date: 26 Dec 2006)	TAKE ONE TABLET BY MOUTH EVERY MORNING
GABAPENTIN (NEURONTIN)--PO 300MG CA (Order Date: 26 Dec 2006)	TAKE ONE CAPSULE BY MOUTH TWICE A DAY
BUSPIRONE (BUSPAR DIVIDOSE)--PO 15M (Order Date: 26 Dec 2006)	TAKE ONE TABLET BY MOUTH EVERY MORNING
ARIPIPRAZOLE (ABILIFY)--PO 10MG TAB (Order Date: 26 Dec 2006)	TAKE ONE TABLET BY MOUTH EVERY NIGHT

9. PENDING LABS:
** NO PENDING LABS **

10. PENDING RADS:
** NO PENDING RADS **

11. FUTURE APPOINTMENTS:

11.5. FOLLOW-UP APPOINTMENT:
above as
Physician:
Clinic:
Date/time:

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12. DIET:
regular

13. CONDITION AT TIME OF DISCHARGE: improved; no suicidal or homicidal ideation

14. STAFF PHYSICIAN: IMURA,MICHAEL K

15. NARRATIVE SUMMARY DICTATED:
RESPONSIBLE PHYSICIAN: FUJIOKA,BRIAN K

Yes, I have reviewed the outpatient medications and certify that these are correct at the time of discharge.

IMURA,MICHAEL K — 27 Dec 2006@0833

Physician Signature — Date

16. DISCHARGE TO: HOME MODE: AMBULATORY
ACCOMPANIED BY: UNACCOMPANIED

If transferred to another health care facility, report called to nurse: NA

EQUIPMENT/SUPPLIES PROVIDED:

All discharge medications given to patient at time of discharge.

17. ALLERGIES:
PENICILLINS

18. NURSING TREATMENTS/CARE INSTRUCTIONS:
Instructed and encouraged patient to follow doctor's instructions and take all meds as ordered and prescribed.

Medications Explained by: DOCTOR
Printed medication literature provided: YES
Patient/Care-giver states understanding of prescribed medications: YES

19. REFERRAL TO:

20. PATIENT CONDITION (HEALTH STATUS RELATIVE TO NURSING CARE PLAN)
Patient contracted for safety to self and others. Patient denied suicidal and homicidal ideation. Patient verbalized understanding of OP10 contents, medications and follow up appointments. Patient was discharged with all personal belongings, a copy of this OP10 given to patient. NCP goals met.

21. PATIENT/SIGNIFICANT OTHER VERBALIZES KNOWLEDGE OF ABOVE INSTRUCTIONS:

ACOSTA,MARISSA R — 27 Dec 2006@0839

Nurse Signature — Date

I UNDERSTAND AND HAVE RECEIVED A COPY OF THE ABOVE INSTRUCTIONS:

Patient/Significant Other Signature — Date 12/27/06

For more health care information:
Visit Tripler's Health Education Center located on the 1st floor, ocean side entrance next to the Community Library in room 1A-001. Hours of operation are Mon-Fri 0830-1800 & Sat 1100-1500. For more information, call 433-2176/2565